UB 373
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1922
Copy 2

Manual of Procedure

To be used by

United States Army and Navy

for

Presenting Claims of Ex-Service Men

United States Veterans' Bureau

Allotment and Allowance
Compensation (ex-service men)
Insurance Status
Compensation (dependents)
Insurance Claims

Miscellaneous

Allotment Refund (Bonus Pay)
Deceased Soldiers' Effects
Deceased Soldiers' Pay Due
Deceased Soldiers' Bonds
Liberty Bonds
Lost Discharge
Reissue of Uniform
Travel Pay
Vocational Training

Prepared by the

United States Veterans' Bureau
C. R. Forbes, Director

22-26471

1922
First Edition

Washington
Government Printing Office
1922

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1922

MANUAL OF PROCEDURE FOR PRESENTING CLAIMS OF EX-SERVICE MEN.

UNITED STATES VETERANS' BUREAU,
Washington.

Promptness in the payment of claims by the United States Veterans' Bureau depends upon the completeness with which each claim is presented.

If claims are submitted piecemeal, each piece must go to the file until by correspondence the entire list of claims requirements is assembled. Each such case takes up the time and attention of various employees, and precludes the possibility of the prompt service which it is desired be accorded all claims.

Exact procedure to follow in handling each class of inquiry together with such forms are needed to be filled in to make the claim complete are indicated. Where forms of bureaus other than the United States Veterans' Bureau are omitted because of bulk, an address is given indicating where these forms may be procured, although each United States Army or Navy recruiting station and United States Army cantonment will have a supply on hand, which can be obtained by writing to the personnel adjutant.

The instructions in this manual concerning other Government departments have been approved by each such department and are presented to coordinate our service and yours to ex-service men and their dependents. I have been glad to bring them together in order to place at your disposal every means of expediting to the utmost degree all classes of inquiries you may be called upon by ex-service men to make; thus carrying out the instruction conveyed by General Order No. 27, War Department, dated July 1, 1921, and General Order No. 64, Navy Department, dated August 3, 1921.

On August 9, the Sweet bill, creating the United States Veterans' Bureau providing for complete decentralization, was passed, and, in order that you may receive the prompt service which it is my desire to extend to you, it is suggested that, in all instances, claims of every character be presented through the nearest subdistrict office, the location of which will be found on pages 26–31.

C. R. FORBES, *Director.*

GENERAL ORDERS, No. 27.

WAR DEPARTMENT,
Washington, July 1, 1921.

Assistance for ex-service men in their relations with the United States Veterans' Bureau.—1. It is the purpose of the War Department, acting through its available personnel, to assist ex-service men in every possible way in securing contact with the United States Veterans' Bureau, thus enabling them without delay to renew or convert their insurance, to secure medical or dental treatment, hospitalization or vocational training, or to present their claims for compensation.

2. The obligation is imposed upon all personnel adjutants throughout the Army, recruting officers, and Regular officers on duty with the National Guard and Organized Reserves, to aid their less fortunate comrades. Such officers will at once familiarize themselves with the orders and circulars relating to the United States Veterans' Bureau in so far as these instructions refer to renewal or conversion of insurance, compensation, medical or dental treatment, hospitalization, and vocational training, so that intelligent assistance and advice may be afforded ex-service men in regard to their relations with the bureau.

3. The officers mentioned will obtain without delay direct from the United States Veterans' Bureau a supply of all blank forms needed by ex-service men in their contact with this bureau.

4. Upon application from ex-soldiers, the officers mentioned in paragraph 2 will furnish blank forms, will assist in the preparation of applications, will carefully examine all papers or instructions on the forms in question, and will themselves promptly forward the completed applications or statements directly to the United States Veterans' Bureau, Washington, D. C.

(004, 61, A. G. O.)

BY ORDER OF THE SECRETARY OF WAR:

JOHN J. PERSHING,
General of the Armies,
Chief of Staff.

Official:
J. T. KERR,
Adjutant General.

GENERAL ORDER No. 64.

NAVY DEPARTMENT,
Washington, D. C., 3 August, 1921.

ASSISTANCE GIVEN EX-SERVICE MEN IN OBTAINING CONTACT WITH THE UNITED STATES VETERANS' BUREAU.

1. It is the purpose of the Navy Department to assist ex-service men in every possible way in securing contact with the United States Veterans' Bureau, thereby enabling them to renew or convert in-

surance, secure treatment, hospitalization, or vocational training or present compensation claims.

2. To accomplish this purpose all ships and stations will at once familiarize themselves with the orders and circulars of the United States Veterans' Bureau relating to the above-mentioned benefits, and receiving ships and recruiting stations will obtain from that bureau a supply of all blank forms needed by ex-service men in their contact with that bureau.

3. Upon application from ex-Navy men all possible assistance will be given by receiving ships and recruiting stations in preparing necessary papers and blanks and forwarding to the United States Veterans' Bureau.

THEODORE ROOSEVELT,
Acting Secretary of the Navy.

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COMPENSATION OF DISABLED EX-SERVICE MEN.

Procedure.—When you find an ex-soldier, sailor, or marine who appears to be entitled to compensation:

Obtain from the nearest subdistrict office, United States Veterans' Bureau, Form 526, the initial claim blank, and Form 545, upon which discharge is to be copied, as these are required in order to present a claim. Form 526 should be filled out in every detail and duly signed by the claimant, and in addition two persons should be requested to witness the execution of this form. After this is done, the form should be acknowledged and sworn to before and duly executed by an officer empowered to administer oaths, or a duly-authorized representative of the United States Veterans' Bureau. When these two blanks are properly filled out and duly sworn to before the proper official, they may either be mailed to the subdistrict office or presented in person. If they are mailed, a letter should accompany the forms requesting that the subdistricit office authorize a medical examination of the claimant; if the papers are presented in person at the subdistrict office, the manager in charge is empowered to authorize examination to be held while the claimant is waiting.

If hospitalization is found necessary, the proper authority is obtainable through the medical officer in charge of the work at the subdistrict office.

It is suggested that all claims concerning compensation, insurance, vocational training, medical treatment or hospitalization, be presented through the nearest subdistrict manager whose address will be found on pages 26–31. By availing yourselves of the services of our subdistrict offices you will materially expedite the adjudication of all claims.

All matters pertaining to war risk, vocational training, and United States Public Health Service, in so far as they relate to the disabled soldier, are now incorporated. No separate form, therefore, is necessary in presenting a claim for vocational training, and full instruction as to the procedure in such cases is given on page 17 of this manual.

UNITED STATES VETERANS BUREAU.
Form 526—Revised August, 1921.

C.....

APPLICATION OF VETERAN DISABLED IN THE WORLD WAR FOR COMPENSATION AND VOCATIONAL TRAINING

DIRECTIONS

READ WITH GREAT CARE

All papers submitted with reference to this claim should bear your full name, also your rank and organization in the service.

You must furnish the information called for in this application and support your answers by the proof called for in the following instructions. Every question must be answered fully and clearly. Answers and affidavits must be written in a clear, readable hand, or typewritten. If you do not know the answer to any question, say so.

I. Forward a certified copy of your certificate of discharge from the service with this application.

II. If you have been attended by any physician since your discharge you should secure from that physician a record of your case, giving the diagnosis, prognosis, the dates of treatment, and in the opinion of the physician, the origin, nature, and probable duration of your disability, attaching his statement to this form.

III. If you are married, you must submit to the Bureau evidence of your marriage by one of the following methods:

(1) Verified copy of the public or church record; or
(2) By the affidavit of the clergyman or magistrate who married you; or
(3) By the affidavits of at least two eye-witnesses to the ceremony; or
(4) By the affidavits of two persons who know that you lived together as husband and wife and are recognized as such, stating in their affidavit how long such relation continued.

IV. In making claim for additional compensation for children, evidence that they are your children must be submitted in any one of the following forms:

(1) By certified copy of the public record of birth; or
(2) By certified copy of record of baptism; or
(3) By the affidavit of the persons showing that the records are not obtainable and giving the name of the child, date, and place of birth and names of parents.
(4) If a stepchild, affidavits from two persons must be made showing that the stepchild is a member of the disabled soldier's household and that the stepchild's own father, if living, assumes none of the responsibility for the stepchild's support and is receiving no dependency allowance for the stepchild.
(5) If adopted child, certified copy of the court order or decree of adoption must be forwarded.

V. If additional compensation is claimed for dependent parents, relationship must be shown in one of the following forms:

(1) By certified copy of the public records of the disabled soldier's birth; or
(2) By a certified copy of the church record of his baptism.
(3) If the above are not obtainable, by the affidavits of two persons who have knowledge of the relationship.
(4) If persons for whom additional compensation is claimed are foster parents, Form 524 (Affidavit of person claiming to have stood in the relation of parent) should be procured, filled out in full, executed, and forwarded with this application. If same can not be procured, state in answer to question No. 35, in this application, that parents are foster parents, and necessary forms will be forwarded to you for execution.

VI. If additional compensation is asked for dependent brothers or sisters or others on account of whom maintenance and support allowance may be granted to trainees under the provisions of section 2 of the Vocational Rehabilitation Act, information must be furnished as called for in questions 39, 40, and 41.

VII. If dependents of the applicant who are over 18 years of age reside abroad or in a place remote from the applicant's residence at the time this application is filed, a duplicate copy of this application should be sent to such dependents for the execution of the necessary affidavits.

PENALTY

That whoever in any claim for family allowance, compensation, or insurance, or in any document required by this act, or by regulations made under this act, makes any statement of a material fact knowing it to be false, shall be guilty of perjury and shall be punished by a fine of not more than $5,000 or by imprisonment for not more than two years, or both. (Sec. 25, Act of October 6, 1917.)

62—6764

[Page 2 of Form 526.]

APPLICATION FOR COMPENSATION AND VOCATIONAL TRAINING

A. PERSONAL HISTORY.

1. Full name..... (Last Name.) (First Name.) (Middle Name.)
2. Address..... (Number.) (Street.) (City or Town.) (State.)
3. Under what name did you serve?.....
4. Color..... Date of birth..... Place of birth.....

B. MILITARY EXPERIENCE AND RELATED INFORMATION.

5. Make a cross (X) after branches of service you served in:
   General Service..... Limited Service..... Army..... Navy..... Marine Corps.....
   Coast Guard..... (*a*) Give Serial No. .....
6. Date you last entered service.....
   Place of entry.....
7. Date of last discharge..... Place of discharge.....
8. Company and regiment or organization, vessel on which, or station in which, you *last* served.....
   .....
9. Rank or rating at time of discharge.....
10. Nature of discharge: Honorable.....; Ordinary.....; Dishonorable.....; Bad conduct.....; S. C. D. .....
11. Nature of disability claimed..... Degree of disability.....
12. Date disability began.....
13. Cause of disability.....
14. Where received.....
15. Did you receive treatment at an Army or Navy Hospital, or any other hospital?.....
    (*a*) If so, state name and location of the hospital and dates of treatment.....
    .....
16. If the injury was caused through the fault of some person other than the United States or the enemy, state whether suit has been commenced against, or settlement made with such person on account of such injury: ..... If settlement has been made or damages recovered state which, and the amount: .....

C. OCCUPATIONAL EXPERIENCE.

17. What was your principal occupation or trade before entering the service?
    ..... (Occupation.) (Monthly wages.) (Date.)
18. Give any other occupation or trade in which you were engaged:
    ..... (Occupation.) (Monthly wages.) (Dates.)
    ..... (Occupation.) (Monthly wages.) (Dates.)
19. Last two employers before entering the service:
    ..... (Employer's name.) (Address.) (Time employed.)
    ..... (Employer's name.) (Address.) (Time employed.)
20. Occupations since discharge, dates of each, and wages received. If less than before, why?.....
    ..... (Occupation.) (Commencing date.) (Ending date.) (Monthly wages.)
    ..... (Occupation.) (Commencing date.) (Ending date.) (Monthly wages.)
21. Present employer..... (Full name.) (Address.)

D EDUCATIONAL HISTORY.

22. How far did you go in grade school?..... In high school?.....
23. What other schooling have you had, such as college, Army or Navy school, night school, correspondence school, etc. (Answer fully.) .....
    .....
    .....

E. MEDICAL DATA.

24. Name and address of physicians who have since discharge attended you for your disability.....
    .....
25. Are you confined to bed?..... Do you require constant nursing or attendant?.....
26. Name and address of nurse or attendant.....
27. Are you willing to accept medical or surgical treatment if furnished?..... 62—6756

[Page 3 of Form 526.]

F. FAMILY OBLIGATIONS AND DEPENDENCY CLAIMS.

28. Are you single, married, widowed, or divorced? .....
29. Times married..... Date and place of last marriage.....
30. Times present wife has been married.....
31. Do you live together? ..... (*a*) If not, state why you are not living together, and your wife's present address.....
32. Give below the information required concerning each dependent child under 18 years of age and unmarried.

Name of Child	Date of Birth			Name and Address of Person with Whom Child Lives
	Day	Month	Year	

33. If any child mentioned in question 32 is an adopted child, give name of such child and date of adoption..... If a stepchild, give name and date such child became a member of your household.....
34. Have you a child of any age who is insane, idiotic, or otherwise permanently helpless? ..... If so, give name and age.....
35. Give name and address of each parent living.....
.....
36. Age of mother.....years.
37. Age of father.....years.
38. (*a*) Is your mother now dependent on you for support? .....
(*b*) Is your father now dependent on you for support? .....
39. If compensation is claimed on behalf of either parent, or both, answer the following questions:
(*a*) Are they living together? ..... (*b*) Widowed or divorced? .....
(*c*) Are they incapable of self support? (Yes or no).....
(*d*) If so, how is each incapacitated? Mother.....
Father .....
(*e*) The average monthly contribution you gave to your mother, $.....; your father, $.....
(*f*) Value of all property owned by your mother, $.....; your father, $.....
(*g*) What is the monthly amount of money received by your mother from all sources, $.....; your father $.....
40. If you claim disability of father, a physician's certificate must be attached hereto showing to just what extent he is incapacitated.
41. Give the following information concerning *all* of your brothers and sisters. If you have none, write "None" in blank space below.

Name	Age.	Residence	Married.	Occupation	Annual Income.

[Page 4 of Form 526.]

G. MISCELLANEOUS INFORMATION

42. Did you make an allotment of your pay while in the service? .....

43. If so, to whom? .....

44. Give number of any other compensation claim filed on account of this disability and place where filed .....

45. Did you ever apply for War Risk Insurance? ..... (*a*) When? .....

(*b*) Where? ..... (*c*) Amount? .....

46. Name of beneficiary in application for insurance .....

47. Have you since changed the beneficiary to some other person? .....

(*a*) If so, to whom? .....

48. Have you ever previously applied for vocational training? .....

Give facts briefly .....

.....

.....

.....

I make the foregoing statements as a part of this application with full knowledge of the penalty provided for making a false statement as to a material fact in a claim for compensation, insurance, or vocational training.

.....
(Signature of claimant.)

Subscribed and sworn to before me this ..... day of ..... 192 ,

by ....., claimant, to whom the statements herein were fully made known and explained.

[SEAL]

.....
Notary Public

We, the undersigned, severally solemnly swear that we have known the claimant whose name is subscribed above ..... years, and that we have read the statements made by him, and the facts stated are true to the best of our knowledge and belief.

..... (Signature of witness.)	..... (Address of witness.)
..... (Signature of witness.)	..... (Address of witness.)

Subscribed and sworn to before me this ..... day of 192

[SEAL.]

.....
Notary Public.

(If no dependents over 18 years of age are claimed the following supporting affidavit should not be executed)

SUPPORTING AFFIDAVIT

STATE OF .....
} *ss:*
COUNTY OF .....

We, the undersigned dependents over 18 years of age, do solemnly swear, for himself and herself individually, that we have read, or had read to us, the foregoing questions and answers; that we understand the same; that we are the persons named in said answers as dependents; and that the statements contained therein as to relationship and dependency of each of us toward said applicant are true.

..... (Signature of affiant.)	..... (Signature of affiant.)
..... (Signature of affiant.)	..... (Signature of affiant.)

SUBSCRIBED and sworn to before me this ..... day of 192

[SEAL]

.....
Notary Public.

COPY OF DISCHARGE CERTIFICATE TO BE USED ONLY WITH CLAIMS AGAINST THE UNITED STATES VETERANS BUREAU

Honorable Discharge

FROM

The United States Army

[COPY]

To all whom it may concern:

This is to Certify, *That* _____

_____

THE UNITED STATES ARMY, as a Testimonial of Honest and Faithful Service, is hereby

Honorably Discharged

from the military service of the UNITED STATES by reason of _____

_____

Said _____ *was born*

in _____, *in the State of* _____;

when enlisted he was _____ *years of age, and by occupation a* _____;

he had _____ *eyes,* _____ *hair,* _____ *complexion, and*

was _____ *feet* _____ *inches in height.*

Given *under my hand at* _____, *this*

_____ *day of* _____, *one thousand nine hundred and* _____

_____

_____

2—9621

Commanding.

Form 545—Rev. Oct., 1921

[Page 2 of Form 545.]

ENLISTMENT RECORD
[COPY]

Name _____ *Grade* _____

Enlisted or Inducted _____, *19*____, *at* _____

Serving in _____ *enlistment period at date of discharge.*

Prior service _____

_____

Noncommissioned officer _____

Marksmanship, gunnery qualifications or rating _____

Horsemanship _____

Battles, engagements, skirmishes, expeditions _____

_____

_____

Knowledge of any vocation _____

Wounds received in service _____

Physical condition when discharged _____

Typhoid prophylaxis completed _____

Paratyphoid prophylaxis completed _____

Married or single _____ *Character* _____

Remarks _____

_____

_____

Signature of soldier _____

I hereby certify that the foregoing is a true, literal, and exact copy of the discharge certificate of _____

_____

Notary Public or Summary Court Officer.

_____

_____

Commanding _____

My commission expires _____

(THIS MUST BE ATTESTED BY A PERSON AUTHORIZED TO EXECUTE OATHS)

8—9671

COMPENSATION—DEPENDENTS.

Procedure.—If you find a wife, child, or dependent of a *disabled* soldier, sailor, or marine, it will not be necessary for any form to be filled out other than initial Form 526. The additional evidence required in such cases is fully explained on page 1 of Form 526 (revised), and before the claim is filed instructions should be followed in every detail, as by doing so unnecessary delay will be obviated.

If you find a widow, child, or parent of a *deceased* soldier, sailor, or marine, have that person or persons fill out very carefully Form 527—Application for Death Compensation. Instructions as to the execution of this form will be found on page 1 of said form and should be made to the subdistrict office located in the subdistrict which has jurisdiction over the residence of the claimant. After this form has been filled out entirely and all questions answered, the same should be forwarded to the subdistrict office mentioned above.

The two witnesses will add their affidavits in the space provided on the back page. This is necessary to determine whether under the law the persons applying are in the class of dependent relatives to whom compensation is payable.

Where applications are made for both parents, both must execute the affidavit; where application is made for a minor child, the compensation, if awarded, can be paid only to a legally appointed guardian; a copy of the guardian's appointment by the court should be forwarded with this claim.

This copy must be certified by the clerk of the court making the appointment, as a certification before a notary public is not sufficient under the act.

TREASURY DEPARTMENT,
BUREAU OF WAR RISK INSURANCE.
Form 527.—Revised Jan., 1919.

File No. C—

APPLICATION OF WIDOW, CHILD, or/and DEPENDENT PARENT.

READ WITH GREAT CARE.

This form is a blank application for compensation only. It is not a claim for insurance, which is separate and distinct from compensation and must be applied for on a different form.

This application should be filled out, signed at the end, witnessed, and sworn to before an official empowered to acknowledge oaths. Every question must be answered fully and clearly in ink, in a clear readable hand, or typewritten. If the answer to any question is not known, the statement, "I don't know," will be sufficient. No award of compensation will be made until formal application has been made and the necessary proof has been submitted.

If application is made on account of death that did not occur in the service, a certified copy of the public record of death must be submitted and, if possible, a certified copy of the deceased's certificate of discharge from the service.

A. PROOF OF WIFE.

Marriage must be proven by a certified or verified copy of the public or church record, or the affidavit of the clergyman who officiated, or the affidavits of two eye witnesses to the ceremony, or the affidavits of two persons having personal knowledge of the marriage, together with affidavit stating why record of marriage is not obtainable. A widow who was divorced from a former husband must submit a certified copy of the court order or decree of divorce from her former spouse.

B. PROOF OF CHILDREN.

Ages should be proven by certified copies of the public or church record of birth, or if such records are not obtainable, by the affidavits of two persons.

Stepchild: Affidavits of two persons that child was a member of deceased's household required in support of a claim for compensation for a stepchild.

Adopted child: Adoption must be shown by certified copy of court order or decree of adoption.

Illegitimate child: Must be shown to have been acknowledged in writing by father.

C. PROOF OF DEPENDENT MOTHER AND FATHER.

Relationship must be proven by certified copy of the public record of birth or church record of baptism of the person who was injured or died in the service and the affidavits of two persons identifying the claimant as one of the parents named in such record, or by the affidavit of the physician, midwife, or nurse in attendance at the birth, or by the affidavits of two persons having personal knowledge of the relationship, if public records are not available.

Dependency must be shown by affidavits of two persons, stating the amount of the total annual income of each parent claiming compensation, the amount received monthly by each such parent from each separate source, including the monthly earnings of such parent, if any, and if none, the reason such parent is not capable of self-support. These affidavits must also show the amount contributed monthly by the deceased or disabled person before entering the service and the location and value of all property, real and personal, owned by each such parent, the encumbrances thereon, and the net monthly income therefrom, as well as the source of the affiant's information

All papers which you send this Bureau must bear the full name, rank, and organization of the person injured or killed in the service, as well as the file number in the upper right-hand corner of this form.

[Page 2 of Form 527.]

PENALTY.

That whoever in any claim for family allowance, compensation, or insurance, or in any document required by this act or by regulation made under this act, makes any statement of a material fact knowing it to be false, shall be guilty of perjury and shall be punished by a fine of not more than $5,000, or by imprisonment for not more than two years, or both.

1. Claimant's full name ..... (*a*) Date of birth .....

2. Second Claimant's name ..... (*a*) Date of birth .....

3. Name of person injured or killed in service .....

4. Date and place of his birth .....

5. His relationship to Claimant(s) ..... 6. His color ..... 7. His height .....

8. His occupation before entering the service .....

(*a*) Weekly earnings .....

9. Date and place he last entered the service .....

10. Branch of service he served in: Army ..... Navy .....

Marine Corps ..... Coast Guard ..... Other branch .....

11. His rank or rating at time of last discharge .....

12. Company and regiment or organization, vessel, or station in or on which he was serving .....

13. Describe injury suffered or disease contracted in the service causing death or disability .....

.....

.....

14. Did death result (*a*) while in the service? ..... (*b*) If so, state amount, if any, expended by you for the return home and burial of the body, $..... (*c*) State amount of burial expense, if any, received from Army or Navy, $.....

15. Date of discharge from the service ..... Date of death .....

16. Date when and place where injury or disease causing disability or death was first received .....

17. Nature and extent of disability resulting therefrom .....

.....

18. Occupation and weekly wages since discharge .....

19. If disability or death occurred after discharge or resignation from the service, state: (*a*) Whether claim for compensation was ever filed in this Bureau by the disabled or deceased, and if so, the file number assigned his claim .....

(*b*) Whether he obtained a certificate from the director of the Bureau to the effect that at the time of his discharge or resignation he was suffering from injury likely to result in disability or death, and if so, the number of the certificate of disability ..... (*c*) Whether he ever applied for War Risk Insurance, and, if so, the number of the certificate of insurance issued him .....

20. Was he married or single? ..... If married, how many times? ..... Had he been divorced? .....

21. Date and place of last marriage .....

[Page 3 of Form 527.]

22. Maiden name of wife, if any ..... 23. Is she living? .....

24. Were they divorced? ..... 25. Her present address .....

26. Had she been previously married? ..... 27 Was she divorced from a former husband? .....

28. If so, give date of divorce ..... 29. Has she remarried since death of husband injured or killed in the service? ..... If so, state date of remarriage ..... 30 Has person disabled or deceased any child or children living, including adopted children and stepchildren under 18 years of age and unmarried? .....

31. If so, give name and following particulars of each child to the best of your knowledge and belief:

Full name of child.	Date of birth.			Name and address of person having custody of the child.
	Day	Month	Year	

32. If any child is a stepchild, an adopted child, or an illegitimate child, state the full name of such child, whether a member of the household of deceased, the name of the mother and, if an adopted child, the date of legal adoption .....

.....

33. Name and date of birth of any child of the person on account of whose injury or death claim is made who is insane, idiotic, or otherwise permanently helpless .....

34. Name and address of each parent of the person on account of whose injury or death claim is made .....

.....

.....

35. Are they incapable of self-support? ..... If so, how is each one incapacitated?

(*a*) Mother .....

(*b*) Father .....

36. On whom does each depend for support? (*a*) Mother ....., (*b*) father .....

37. Did the person injured or killed in the service contribute to their support? ..... If so, what amount did he contribute monthly to (*a*) his mother ....., (*b*) his father .....? (*c*) How much of this was for his board? .....

38. Cash value of all property, real and personal (including cash on hand and in the bank, stocks, bonds, etc.), owned by (*a*) mother ....., (*b*) father .....

39. Name and age of each member of the household if father or mother is claimant .....

.....

.....

(*a*) Total monthly earnings of all members of household .....

02—3512

87419°—22——3

[Page 4 of Form 527.]

40. Amount each member of the household contributes monthly to support of each parent claiming compensation .....

.....

41. Total amount received monthly by each parent from all sources: Mother, $.....; father, $..... (*a*) Amount of monthly earnings: Mother, $.....; father, $.....

42. Average monthly expenses during last twelve months of each parent claiming compensation, including actual cost of rent: (*a*) Mother, $.....; (*b*) father, $..... (Include under rent, interest on mortgage paid in place of rent.)

43. Has claimant any other relative who was or is in the military or naval service of the United States? ..... If so, state name, relationship, rank, and branch of service such relative is serving in .....

.....

44. Did claimant ever apply for or receive an allotment of pay or allowance or compensation from the United States or account of any person's service? ..... (*a*) If so, state number of said claim and date and amount of allotment, allowance, or compensation received .....

I make the foregoing statements as part of my claim, with full knowledge of the penalty provided for making a false statement as to a material fact in a claim for compensation or insurance.

....
[Signature of claimant (wife).] [Address of claimant (wife).]

....
[Signature of claimant (mother).] [Address of claimant (mother).]

....
[Signature of claimant (father).] [Address of claimant (father).]

Subscribed and sworn to before me this ..... day of ....., 19....., by ..... claimant(s), to whom the statements herein were fully explained.

.....
Notary Public.

We, the undersigned, severally solemnly swear that we have known the claimant(s) whose name(s) is/are subscribed above ..... years, and that we know said claimant(s) to be the .....
(Relationship to the deceased.)
..... of the deceased .....,
(Name and service of the deceased.)
that we have read the statements made herein, and the facts stated are true to the best of our knowledge and belief.

....
[Signature of witness.] [Address of witness.]

....
[Signature of witness.] [Address of witness.]

Subscribed and sworn to before me this ..... day of ....., 19.....

.....
Notary Public.

INSURANCE CLAIMS.

Procedure.—If person or persons apply to you believing they are entitled to payment of insurance on the death of a soldier, sailor, or marine:

Form 501 should be given to the person applying, with the explanation that the execution of this form of itself does not entitle this person to the insurance, but it will serve as a means of identification and proper checkage against insurance records. Even though that person may possess an insurance certificate, this of itself does not entitle that person to payment under this insurance, as the soldier might have changed his beneficiary without notice, and for the further reason that many men failing to pay the required premiums have allowed the insurance to lapse and be of no effect.

After this form is filled out, the records of the central office will be searched to disclose if the person inquiring is entitled to insurance. Thereby considerable time will be saved in locating the record.

After this form has been executed and forwarded to the nearest subdistrict office, and a further investigation discloses that this person is the beneficiary and entitled to payments of insurance, he will be furnished from the central office with the Form 514 (revised), similar to that shown on the following page, which form is an affidavit to identify the person as the one legally entitled to the proceeds of this insurance and to further substantiate the death of the insured.

After Form 514 has been *fully executed*, it should be submitted to the subdistrict office charged with supervision of the residence of the claimant, to be examined to determine if the affidavit is properly executed, including the seal of the official administering the oath, or its equivalent, and immediately forwarded to the central office.

Form 501 (Revised Aug., 1921) Claim No. C.....

UNITED STATES VETERANS BUREAU

CLAIMS DIVISION

EMERGENCY INFORMATION

WASHINGTON, D. C., ..., 19.....

It appears that .....;
(Name.) (Rank.) (Organization.)

who died ....., 19....., gave your name and address for use in emergency.

Kindly answer the following questions and return this form in the inclosed envelope, which requires no postage. The questions concerning dependency relate solely to Compensation, which is separate and apart from Insurance. Dependency need not be shown by a beneficiary in order to receive Insurance.

.....
Assistant Director.

---

1. Your relationship, if any .....

2. Name of his widow, if any .....

3. Her post-office address .....

4. Names and addresses of his children, if any .....

.....

5. Name and address of his mother .....

.....

6. Was she dependent for support on deceased? .....

7. Name and address of his father .....

.....

8. Was he dependent for support on deceased? .....

9. His insurance certificate number .....

10. Were expenses incurred for the return home and burial of his body? .....

(*a*) If so, by whom? .....

(*Signature*) .....

(*P. O. Address*) .....

VETERANS' BUREAU,
CLAIMS DIVISION.
FORM 514.
Revised July, 1921.

AFFIDAVIT IN SUPPORT OF INSURANCE CLAIM.

(Par. I) I, ... (Name of claimant), residing at ..... (Street and No.)

..... (City or town), ..., (State), believe myself to be the beneficiary of the insurance granted by the United States to ..... (Name of insured) who, I am informed and believe, died at ....., on the ..... day of ....., 19....., as the result of .....

.....

and in support of my claim to such insurance I make the following statement as true to the best of my knowledge and belief: I was born on ..... My relationship to ..... (Name of insured) is that of ..... (Widow, brother, etc.)

For five years preceding his death the insured lived at the following-named places for the periods stated:

.....

.....

The insured was born on ..... day of .....

The insured was ..... married and his { widow and family, or parents } resided at the time of his death at

(If not married, strike out "widow and family.")

..... The only surviving relatives of .....
(Name of insured.)

within the class of spouse, child (including a stepchild, adopted, and illegitimate child), grandchild, parent (including father, mother, grandfather, grandmother, father through adoption, mother through adoption, stepfather, stepmother, and foster parents), brother, sister, uncle, aunt, nephew, niece, brother-in-law, and sister-in-law, of whom I have any knowledge, are as follows:

FULL NAME	RELATIONSHIP	AGE	ADDRESS

(OVER)

c2—1221

[Page 2 of Form 514.]

FULL NAME	RELATIONSHIP	AGE	ADDRESS

I do solemnly swear that the foregoing statements are true to the best of my knowledge and belief.

(Beneficiary's signature in full.)

Subscribed and sworn to before me this ---- day of ----, 192

Notary Public.

(**Par. II**) We, the undersigned, severally solemnly swear that we have known the claimant whose name is subscribed above ---- years, and that we know said claimant to be the ----
(Relationship.)
of ----; that we have read the statements made herein, and the facts as stated are true to the best of our knowledge and belief.
(Name and service of the deceased.)

---, ---
(Signature of witness.) (Address of witness.)

Notary Public.

AFFIDAVIT OF IDENTIFICATION.

(**Par. III**) I, ----, residing at ----
(Number.) (Street.)
in ---- State of ----, first being duly sworn according to law, depose and say that I am ---- years of age and that I have known ----
----, hereinafter called the deceased, for ---- years;
(Name of insured.)
that the said deceased died at ----, in the State of ----, on or about ----, and that I have seen the body and know it to be the body of said deceased.

(Signature of affiant.)

Subscribed and sworn to before me on ----, 192

Notary Public.

PENALTY.

"SECTION 25. That whoever in any claim for family allowance, compensation, or insurance, or in any document required by this act or by regulations made under this act, makes any statement of a material fact knowing it to be false, shall be guilty of perjury and shall be punished by a fine of not more than $5,000 or by imprisonment for not more than two years, or both."

62—4271

ALLOTMENT AND ALLOWANCE—WAR RISK.

If you have any inquiry concerning allotment and allowance, the following procedure pertains:

July 31, 1921 was fixed by law as the date of discontinuance of all payments of allotment and allowance by the United States Veterans' Bureau, and no allotment or allowance will be paid by the United States Veterans' Bureau covering any period from and after August 1, 1921.

The period of war risk payments of allotment and allowance runs from November 1, 1917 to July 31, 1921. If an amount of allotment or family allowance, or both, is due for any portion of that period, payment will be made at any time hereafter as follows:

(1) If you desire information relative to payment or further payment of allotment or family allowance due or unpaid for any period between November 1, 1917, and July 31, 1921, address your inquiry to the nearest subdistrict office, United States Veterans' Bureau, giving the full name of the enlisted man, the company and regiment in which he served, and the allotment or serial number of the case.

(2) After August 1, 1921, all allotments are voluntary and will be made under regulations to be provided by the Secretary of War, or the Secretary of the Navy, as the case may be. After August 1, 1921, inquiries concerning allotments made by persons now in active service should be addressed as follows:

Army—Finance Office, War Department, Washington, D. C.

Navy—Navy Allotment Office, Navy Department, Washington, D. C.

Marines—Major General Commandant, Marine Corps, Washington, D. C.

Coast Guards—Captain Commandant, Coast Guard, Washington, D. C.

If you address your correspondence strictly in accordance with the foregoing and give sufficient data to identify the person from whom an allotment is expected, service on these cases will be materially expedited.

ALLOTMENT REFUND—ARMY OR NAVY.

Procedure.—If you find an ex-service man desiring refund of amounts erroneously deducted from his pay and not repaid during his service either to the allottee or to him:

Assist the applicant, if an ex-soldier, to write to the General Accounting Office, War Department Division, Washington, D. C., explaining his case fully and giving amounts and dates of deduction, Army serial number, and any information which will be of assistance.

If the applicant is an ex-sailor or marine, he should make claim to the General Accounting Office, Navy Department Division, Washington, D. C.

This procedure applies to allotments which did not carry allowance and to Class A allotments from which exemption was claimed when no amounts have been paid to either the allottee or to the ex-service man.

BONUS PAY.

Procedure.—If you find a soldier who has not received his $60 bonus:

Cause him to fill out Form A–2, which follows this page, and which you may obtain from Room 1115, United States Veterans' Bureau, Washington, D. C.

Have him inclose it with his original discharge, on the back of which he has written his mail address. (NOTE.—Payment also will be made on a copy of the discharge certificate *only* if it is certified to by a United States Army recruiting officer.) Mail the discharge and the form to **the Finance Office, U. S. Army, Lemon Building, Washington, D. C.**

His discharge and the $60 bonus will be sent direct to him.

If he previously has done this and has not heard from it within a reasonable time, write, giving his full name, serial number, organization, and address, together with all details of the situation and the place and date of his discharge, to nearest United States Veterans' Bureau Office, who will take it up promptly.

NOTE.—The bonus is *not* payable to (1) any person who did not arrive at his camp or station before midnight of November 11, 1918; (2) any person entitled to retirement pay; (3) heirs or legal representatives of a deceased person; (4) anyone discharged or separated from the service under conditions not honorable.

Navy.—Released, discharged, or disenrolled members' applications go to "Disbursing Officer, Bureau of Supplies and Accounts, Navy Department, Washington, D. C."

Marine Corps.—Those applications go to "Paymaster, U. S. Marine Corps Headquarters, Washington, D. C."

Coast Guard.—Those claims go to "Allotment Disbursing Officer, Coast Guard Headquarters, Washington, D. C."

From: _____, Serial No. _____
To: Finance Officer, Bonus Section, Washington, D. C., or
To: Disbursing Office, Navy Department, Washington, D. C.
Subject: Bonus.

1. I respectfully make application for the $60 bonus for discharged service men, inclosing herewith my discharge certificate, and in connection herewith submit the following information concerning my service:

Place of enlistment _____ _____. Date _____

Organizations in which I served: _____

_____

_____

Place of discharge _____ _____. Date _____

2. My mail address, to which I desire the bonus and my discharge certificate sent, is:

_____

_____.
(Sign on above line.)

A–2.

DECEASED SOLDIER—EFFECTS.

Procedure.—If you find a relative of a deceased soldier who has not received the soldier's effects:

Assist that relative to prepare a letter having at the top the soldier's name, organization, and serial number, and giving in the letter the date and place of death, which will be sent to **The Adjutant General, U. S. Army, Washington, D. C.**

Two blanks will be returned, one to be filled out before a notary public with two witnesses. When completed, please return them as directed on the forms. These effects will not contain his money, back pay, or Liberty bonds, which are obtained from other Government departments.

DECEASED SOLDIER—LIBERTY BONDS.

Procedure.—If you find a relative of a deceased soldier who believes the soldier left Liberty bonds wholly or partly paid for:

Assist him to fill out the form shown on the following page, A–3, which may be obtained from the Finance Officer, United States Army, Washington, D. C., or, in the case of a sailor or marine, apply to the General Accounting Officer, Navy Department Division, Washington, D. C.

When this is completed and every question answered accurately, please forward to the State United States Veterans' officer, who will check it against his files and will mail it to **Finance Officer, U. S. Army, Washington, D. C.**; or **General Accounting Officer, Navy Department Division, Washington, D. C.**

It will be explained to the inquirers that filing this claim does not, by itself, entitle them to bonds; that these bonds are delivered to that person who under the laws of the State in which the soldier resided would be entitled to his personal property in the event he died without leaving a will.

Some of these bonds will be delivered finally by the Comptroller General, General Accounting Officer, War Department Division, Washington, D. C., but all must be checked first by the Finance Officer. If, in replying, you are notified that the claim has been sent to the Comptroller General, you will know that the claim is on the way to prompt settlement.

NOTE.—If you apply also, in a separate claim, for pay due the soldier at time of death, the method for which is explained on another page, even though you have followed the above direction for obtaining Liberty bonds, include in your application for pay due at death a statement you also wish the Liberty bonds; this is so that the Comptroller General may check up with the Finance Officer.

APPLICATION FOR LIBERTY BONDS, DECEASED SOLDIER.

_____.

_____ 1921.

_____

_____

SIR: _____
(Full name of deceased.) (Rank.)

_____ Army Serial No. _____
(Organization.)

enlisted _____ 19_____, and while stationed at

_____, as a _____
(Rank.)

_____, made an allotment to the
(Organization.)

_____ for Liberty Loan Bonds of the
(See note.*)

_____ issue on _____ 19_____.
(Second, Third, or Fourth.)

Payments on this allotment were completed _____, 19_____,

while deceased was a _____.
(Rank.) (Organization.)

Date of death _____, 19_____. I believe myself legally entitled to these bonds and request that they be sent to me at the following address:

_____.
(Full name of applicant.)

_____.
(Mail address.)

Relationship to deceased _____.

---

* Third and Fourth Liberty Loan allotments were to the Secretary of the Treasury. Second Liberty Loan allotments were to the Federal Reserve Bank of New York.

A–3.

DECEASED SOLDIER, SAILOR, OR MARINE—PAY DUE AT DEATH.

Procedure.—If you find a relative of a deceased soldier, sailor, or marine seeking pay due him at death:

Assist the relative to prepare a letter, at the top of which has been written the name, organization, and serial number of the deceased, to be sent to the Comptroller General, General Accounting Office, War Department, War Department Division, Washington, D. C., or Navy Department, Washington, D. C.

The letter should give a list showing the names, ages, and mail addresses of the living relatives of the service man in the following classes: Wife, children, grandchildren, parents, brothers, and sisters.

The Comptroller General will send the relative the proper blank which you can assist in filling out with two witnesses, and then return direct to the General Accounting Officer, War or Navy Department Division.

Please see that each question is answered accurately and completely before forwarding it.

This is to procure the pay which was due the soldier, sailor, or marine at the time of his death, together with all sums he had deposited with the quartermaster, or Navy supply officer, and does not include Liberty bonds, which he has paid for; method of obtaining them is explained on the following pages.

NOTE.—Even though you have applied separately, in accordance with directions on page 19 for Liberty bonds, be sure to mention them in this application for lost pay, so that the Comptroller General may check up with the Finance Officer before making settlement.

LIBERTY BONDS.

Procedure.—If you find a soldier who has not received his Liberty bonds:

Assist him to fill out the affidavit form covering the particular bond issue about which he inquires, which forms may be obtained from the Finance Officer, United States Army, Washington, D. C., or, in the case of a sailor or marine, apply to the Disbursing Officer of Supplies and Accounts, United States Navy, Washington, D. C.

When making out this form, be sure that for each month he not only states the name of the organization in which he was serving, but also the *place* at which he was stationed that month.

NOTE.—Inquiries concerning Victory bonds (fifth issue) purchased by persons who have been discharged from the service should be addressed to Finance Officer, United States Army, Washington, D. C., Victory Bond Section, or, in the case of a sailor or marine, apply to the Disbursing Officer of Supplies and Accounts, United States Navy, Washington, D. C." In all inquires great care should be taken in having the date of discharge correct; if possible, this should be verified from the discharge certificate of the soldier.

LOST DISCHARGE.

Procedure.—If you find a soldier who has lost his original discharge certificate:

Help him to fill out Form 214, A. G. O., which you may obtain from The Adjutant General, Washington, D. C., or in the case of a sailor or marine, the proper form may be obtained from the Bureau of Navigation, Navy Department, Washington, D. C.

With two witnesses, have the form filled out carefully and accurately and sworn to before you. When it has been completed forward to The Adjutant General, with a request that the certificate be sent direct to the soldier.

In this connection it is well to remember that a lost or destroyed discharge certificate can not be duplicated or replaced, the certificate of service is simply a certificate of what the records show in Washington, and does not give battles, wounds, or honors.

After it has been received, the soldier may write to The Adjutant General and ask permission to return it to have entered upon the face of it this information. In making such a request, the soldier should indicate the names and dates of the battles, giving the organization in which he served in each; the places and dates where he was wounded, with the name or number of the field hospital, evacuation hospital, or base hospital which treated his wounds, and the dates and order number under which he was issued medals.

This should not be included in the original request for a certificate of service, for, however strange it may seem, time can be saved by making independent requests as indicated.

In making this request the certificate should not be sent until The Adjutant General says he is ready and sends for it.

BACK PAY.

If you find an ex-soldier who has not received his back pay, he should write a letter over his signature, giving his name, rank, organization, serial number, date and place of discharge, date and place where last payment was received and period for which payment is due. This letter should be addressed to

THE GENERAL ACCOUNTING OFFICE,
War Department Division,
1734 New York Avenue,
Washington, D. C.

An ex-sailor or marine should address his communication to

THE GENERAL ACCOUNTING OFFICE,
Navy Department Division,
Washington, D. C.

Inquiries regarding *retainer pay* should be addressed to the

NAVY DISBURSING OFFICER,
Bureau of Supplies and Accounts,
Navy Department,
Washington, D. C.

REISSUE OF UNIFORM.

Procedure.—If you find a soldier who believes he is still entitled to part of his uniform equipment:

Advise him that the last appropriations bill passed by Congress repealed the provisions for reissue of uniform on and after June 1, 1921.

All applications for uniform which were on file with the Office of Director of Purchase and Storage, Supply Division, Clothing and Equipage Section, on or before June 1, 1921, will be issued, but no applications will be entertained after that date.

TRAVEL PAY.

Procedure.—If you find a soldier who has not received his travel pay from place of discharge to his place of enlistment or bona fide residence at the rate of 5 cents per mile:

Remember the extra travel allowance is paid only to enlisted men honorably discharged *after* November 11, 1918. A blank form of application Form 2847, which contains the necessary affidavit for the additional travel allowance, may be obtained from the nearest United States Veterans' Bureau Office, the Finance Officer, United States Army, Washington, D. C., or any Army recruiting officer. This affidavit must be accompanied by a true copy of the soldier's discharge certificate certified to *only* by a recruiting officer, or by the original discharge certificate, on the back of which he has written his name and mail address (the original discharge will be returned with his check). If he had submitted a certified copy for payment of the $60 bonus, he should say so in his application for travel pay, and then need not send another one.

All travel pay claims should be forwarded to Finance Officer, United States Army, Lemon Building, Travel Allowance Division, Washington, D. C.

If the soldier claims as his actual bona fide home or residence a place different from that on his service record he must send also an affidavit by himself and other affidavits by two disinterested persons all sworn to before a notary public or other person authorized to administer oaths, which affidavits must state—

(A) Where he actually resided at the time he entered service.
(B) How long he had resided there.
(C) His occupation during that time and for whom he worked.
(D) Where he traveled to when discharged.
(E) Where he is now residing.
(F) Whether he was asked at time of discharge to what place he desired the War Department to send him, or to what place he wanted the Government to pay his transportation.
(G) Place and date of discharge and name of man by whom he was last paid.

A sailor must write direct to Travel Claims Section, Bureau of Supplies and Accounts, Navy Department, Washington, D. C.

VOCATIONAL TRAINING—EMPLOYMENT.

Procedure.—If you find a discharged disabled person or one about to be discharged with a disability who is unable to return to employment because of his disability:

You should advise him to write to the district office or subdistrict office of the United States Veterans' Bureau for the territory in which he resides, advising that he desires to make application for vocational training. The office concerned will send him the necessary forms to be executed and will start the necessary procedure to obtain a medical examination of the claimant. You can assist the applicant in filling out the papers and fully answering the questions to establish his eligibility for vocational training.

A list of the district offices and subdistrict offices throughout the country showing the States they comprise will be found on pages 25–31 of this manual.

UNITED STATES VETERANS' BUREAU.

DISTRICT OFFICES.

JANUARY 1, 1920.

Dist. No.

1.—District Manager, Dr. A. E. Brides, Washington-Essex Building, Boston, Mass. Maine, New Hampshire, Vermont, Massachusetts, Rhode Island.

2.—District Manager, Mr. Henry G. Opdycke, 23 West Forty-third Street, New York, N. Y. New York, New Jersey, Connecticut.

3.—District Manager, Dr. L. B. Rogers, 140 North Broad Street, Philadelphia, Pa. Pennsylvania, Delaware.

4.—District Manager, Mr. Albert E. Haan, Room 206, Arlington Building, Washington, D. C. District of Columbia, Maryland, Virginia, West Virginia.

5.—District Manager, Mr. M. Bryson, 433–439 Peachtree Street, Atlanta, Ga. North Carolina, South Carolina, Tennessee, Georgia, Florida.

6.—District Manager, Col. Dallas B. Smith, New Hibernia Bank Building, New Orleans, La. Alabama, Mississippi, Louisiana.

7.—District Manager, Mr. William M. Coffin, 408 Pioneer Street, Cincinnati, Ohio. Indiana, Ohio, Kentucky.

8.—District Manager, Mr. Chas. W. Spofford, Eighth Floor, Leiter Building, Chicago, Ill. Illinois, Michigan, Wisconsin.

9.—District Manager, Mr. Middleton E. Head, 6801 Delmar Boulevard, St. Louis, Mo. Nebraska, Iowa, Kansas, Missouri.

10.—District Manager, Mr. Carl D. Hibbard, 509 Keith-Plaza Building, Minneapolis, Minn. Minnesota, North Dakota, South Dakota, Montana.

11.—Acting District Manager, Dr. John C. Cornell, Tenth Floor, United States National Bank Building, Denver, Colo. Wyoming, Utah, Colorado, New Mexico.

12.—District Manager Maj. Louis T. Grant, Lincoln Realty Building, 883 Market Street, San Francisco, Calif. Arizona, Nevada, California.

13.—District Manager, Mr. Lewis C. Jesseph, 6147 Arcade Building, Seattle, Wash. Washington, Idaho, Oregon.

14.—District Manager, Mr. Sherman C. Kile, 1503 Pacific Avenue, Dallas, Tex. Oklahoma, Texas, Arkansas.

Subdistrict offices.

District.	State.	Suboffice.
1. Boston, Mass	Maine	Bangor.
		Portland.
	Massachusetts	Lawrence.
		New Bedford.
		Springfield.
		Worcester.
	New Hampshire	Manchester.
	Rhode Island	Providence.
	Vermont	Burlington.
2. New York, N. Y	Connecticut	Hartford.
		New Haven.
	New Jersey	Camden.
		Newark.
	New York	Albany.
		Binghamton.
		Buffalo.
		Poughkeepsie.
		Rochester.
		Syracuse..
		Utica.
3. Philadelphia, Pa	Delaware	Wilmington.
	Pennsylvania	Allentown.
		Erie.
		Harrisburg.
		Johnstown.
		Pittsburgh.
		Scranton.
		Williamsport.
4. Washington, D. C	District of Columbia	Washington, D. C.
	Maryland	Baltimore.
		Cumberland.
	Virginia	Norfolk.
		Richmond.
		Roanoke.
	West Virginia	Bluefield.
		Charleston.
		Clarksburg.
		Wheeling.
5. Atlanta, Ga	Florida	Jacksonville.
	Georgia	Macon.
		Savannah.
	North Carolina	Charlotte.
		Raleigh.
	South Carolina	Columbia.
	Tennessee	Chattanooga.
		Jackson.
		Knoxville.
		Memphis.
		Nashville.
6. New Orleans, La	Alabama	Birmingham.
		Gadsen.
		Mobile.
		Montgomery.
	Louisiana	Lafayette.
		Shreveport.
	Mississippi	Jackson.
		Meridian.
7. Cincinnati, Ohio	Indiana	Evansville.
		Indianapolis.
		South Bend.
	Kentucky	Hopkinsville.
		Lexington.
		Louisville.

Subdistrict offices—Continued.

District.	State.	Suboffice.
7. Cincinnati, Ohio (cont)...	Ohio	Canton.
		Cleveland.
		Columbus.
		Dayton.
		Toledo.
8. Chicago, Ill	Illinois	Centralia.
		Danville.
		East St. Louis.
		Peoria.
		Rockford.
		Springfield.
	Michigan	Detroit.
		Grand Rapids.
		Jackson.
		Marquette.
		Saginaw.
	Wisconsin	Eau Claire.
		Green Bay.
		Madison.
		Milwaukee.
9. St. Louis, Mo	Iowa	Cedar Rapids.
		Des Moines.
		Fort Dodge.
		Waterloo.
	Kansas	Salina.
		Topeka.
		Wichita.
	Missouri	Chillicothe.
		Kansas City.
		Springfield.
	Nebraska	Kearney.
		Omaha.
10. Minneapolis, Minn	Minnesota	Duluth.
		St. Paul.
	Montana	Helena.
	South Dakota	Fargo.
	North Dakota	Sioux Falls.
11. Denver, Colo	Colorado	Colorado Springs.
		Pueblo.
	New Mexico	Albuquerque.
	Utah	Salt Lake City.
	Wyoming	Casper.
12. San Francisco, Calif	Arizona	Phoenix.
		Tucson.
	California	Fresno.
		Los Angeles.
		Sacramento.
		San Diego.
	Nevada	Reno.
13. Seattle, Wash	Idaho	Pocatello.
	Oregon	Portland.
	Washington	Spokane.
		Tacoma.
14. Dallas, Tex	Arkansas	Fort Smith.
		Little Rock.
	Oklahoma	Oklahoma City.
		Tulsa.
	Texas	El Paso.
		Fort Worth.
		Houston.
		San Antonio.
		Texarkana.
		Waco.

FIELD LETTER.

No. 18.

U. S. VETERANS' BUREAU,
December 10, 1921.

RELATIONS OF THE RED CROSS TO THE VETERANS' BUREAU.

District managers are directed to attach to their receiving offices personnel of the Red Cross hitherto engaged in assisting the ex-service man with his problems. Because of the character of the work performed by the American Red Cross now and hitherto, and the relations which it has maintained with large numbers of people throughout the United States, the organization can be of the greatest benefit in enabling the Government to discharge its obligations to disabled soldiers.

The Veterans' Bureau, being strictly a governmental agency, is often prevented from performing work that is essential to the welfare of the ex-service men and their dependents, particularly in matters of domestic finances and relations, family illness, etc. There are unfortunate cases which for legal reasons the Bureau can not assist and cases that require aid while the Government investigates the facts. The Red Cross is the one great agency of a quasi-governmental character that can be of extreme assistance in this direction.

It is the general understanding with the Red Cross that so soon as a sufficient corps of competent persons is trained by the Bureau to give the soldier and his problems the special treatment which they require, this type of work will be relinquished by the Red Cross, but in the meantime the services of the organization will be used to the fullest extent. It is especially understood that the Red Cross work carried on in hospitals will be continued as heretofore.

For the reasons outlined it is important that the fullest possible information be placed within the reach of the Red Cross representatives in the field. If certain unusual and special cases require the admission of Red Cross personnel to the files, this would be permissible, subject to the rules dictated by good office management, such rules not of course permitting the removal of files from the file room, which it is essential that they be immediately available at all times.

C. R. FORBES,
Director, U. S. Veterans' Bureau.

U. S. VETERANS' BUREAU,
August 12, 1921.

GENERAL ORDER NO. 20.

Subject: Documents contained in the files of the Veterans' Bureau and information in regard to transactions of an official character.

The following general order is hereby promulgated for the observance of all officers and employees of the Veterans' Bureau:

No account, document, or paper of any kind shall be withdrawn from the files of the Bureau by agents, attorneys, or other persons; and copies of any accounts or papers shall not be furnished to any

person except upon the written order of the Director, and such copies shall be furnished only to such persons as may have a personal material interest in the subject matter of the papers. An affidavit setting forth the interest of the applicant and showing the purpose for which copies are desired must be submitted with each application.

Except as otherwise herein provided, in all cases where copies of documents or records are desired by or on behalf of parties to a suit, whether in a court of the United States or any other, such copies shall be furnished to the court only, and on a rule of the court upon the Director of the Veterans' Bureau requesting the same. Exceptions to this rule will be made only on the written order of the Director.

In cases where suit instituted in a district court of the United States under the war risk insurance act, copies of documents or records may be furnished the Department of Justice or its officers by the general counsel of the Veterans' Bureau.

No information in regard to transactions of an official character in this Bureau is to be communicated to anyone not authorized to receive the same.

No information in regard to the claim of any person which has ever been filed in the Bureau is to be given to any person unless proper authority is shown by way of power of attorney, or by letters of administration, or otherwise in a manner satisfactory to the Director.

All other general orders or instructions in conflict herewith are modified accordingly.

C. R. FORBES,
Director, U. S. Veterans' Bureau.

INSURANCE STATUS.

Procedure.—If you have an inquiry regarding the status of a service man's insurance:

Assist him to fill out the form following this page, Form A–1, which may be obtained either from the nearest subdistrict office or from the United States Veterans' Bureau, Washington, D. C., Room 1115.

After each question is answered accurately and completely, forward to Insurance Division, United States Veterans' Bureau, Washington, D. C.

REQUEST FOR INFORMATION CONCERNING CONVERTED OR TERM INSURANCE.

To enable the United States Veterans' Bureau to identify your inquiry and determine exactly the status of your insurance, please answer each of the following questions carefully and forward to the Insurance Division, United States Veterans' Bureau, Washington, D. C.

1. My full name is_____
(First name.) (Middle name.) (Last name.)
2. My present address is_____
3. I applied for war risk insurance_____
(Give approximate date.)
_____.
(Give date of additional.)
4. While stationed at_____
(Original.) (Additional.)
5. Home address as given on application was_____
6. Date of birth_____
7. War risk insurance granted under Certificate No_____
_____
8. Rank and organization at date of application_____
_____
(Army serial number.)
9. Date of discharge_____
10. Place of discharge_____
11. Rank and organization at date of discharge_____
_____
12. Last month for which premium was deducted from pay_____
13. Premium rate at date of discharge_____
14. The following payments have been made on war risk, or term insurance since discharge:

Amount.	Transmitted by.	Covered by receipt No.	Dated.	Teller No.
.....	.....	.....	.....	.....
.....	.....	.....	.....	.....
.....	.....	.....	.....	.....

If application for conversion to permanent Government insurance has been submitted, give the following information:

15. Date of application for conversion_____
16. Form of policy_____
17. Amount of policy_____
18. Number of policy_____
19. Amount still carried under war risk, or term, insurance_____
20. The following payments have been made on the new policy.

Amount.	Transmitted by.	Covered by receipt No.	Dated.	Teller No.
.....	.....	.....	.....	.....
.....	.....	.....	.....	.....
.....	.....	.....	.....	.....

GOVERNMENT LIFE INSURANCE.

Government life insurance is divided into two important divisions: First, renewable term insurance; second, level premium (Government life converted) insurance.

YEARLY RENEWABLE TERM INSURANCE.

This form of insurance was adopted for use of the period of the war and for a limited period thereafter. If protection is desired beyond March 4, 1926, term insurance must be converted into some form of level premium insurance.

The premium rate for yearly renewable term insurance is the net rate according to the American Experience Table of Mortality and interest at 3½ per cent per annum, computed for payment on a monthly basis. This premium rate increases from year to year as the insured grows older and becomes prohibitive in later years. Yearly renewable term insurance is payable only in monthly installments of $5.75 for each $1,000 insurance in force.

LEVEL PREMIUM OR CONVERTED INSURANCE.

The fact that the premium on yearly renewable term insurance increases from year to year and becomes prohibitive in later years made it necessary to provide insurance at a premium rate which would remain the same throughout the premium-paying period.

The forms of policies provided by the Government are as follows: Ordinary life, twenty and thirty payment life; twenty and thirty year endowment, and endowment at age 62. All policies provided a selection of options by the insured as to settlement, including settlements in one sum or in monthly installments covering various periods of months in multiples of 12. They also provide that beneficiaries may elect certain options. These options are clearly set forth in the policy.

All forms of policies are participating, which means that if losses are less than provided for by the American Experience Table of Mortality and the interest earnings are greater than 3½ per cent, a sum will accrue due to such deferred mortality and excess interest earnings and from this sum dividends may be declared and paid.

All forms of policies provide for total permanent disability benefits, and there is no charge in the premium for this protection. There is no limit as to the age of the insured when such total permanent disability may begin.

The Government is not in competition with commercial companies and it is urged that no statements be made concerning them. If an insured states a certain policy is better than the Government's policy, have him secure a specimen with rates and send it to the Assistant Director, Insurance Division, and a comprehensive and unbiased comparison will be made of the two policies and forwarded both to the insured and the field representative.

A BRIEF SYNOPSIS OF REINSTATEMENT REQUIREMENTS AS PROVIDED FOR IN REGULATIONS NOS. 14 AND 15.

UNITED STATES GOVERNMENT TERM INSURANCE.

Term insurance which has lapsed or has been canceled may be reinstated in whole or in part under the following provisions:

A. Within three calendar months, including the calendar month for which the unpaid premium was due, provided the applicant is in as good health as he was at the due date of the premium in default and forwards with his application for reinstatement (first page of Form 742 or Form 744 complete) a remittance covering two premiums on the amount of insurance to be reinstated, one for the month of grace and one for the current month.

B. After the expiration of the three calendar months mentioned in clause A, and prior to March 4, 1926, provided the applicant is in good health and submits an application for reinstatement (Form 742) completely executed, with a remittance covering two premiums on the amount of insurance to be reinstated, one for the month of grace and one for the current month.

If term insurance is reinstated under the provisions as outlined above for the purpose of conversion, but one premium on the term insurance and the first monthly, quartely semiannual, or annual premium on the converted insurance is necessary.

UNITED STATES GOVERNMENT CONVERTED INSURANCE.

United States Government converted insurance which has lapsed may be reinstated in whole or in part under the following provisions:

A. Within three calendar months, including the calendar month for which the unpaid premium was due, provided the applicant is in as good health as he was at the due date of the premium in default and forwards with his application for reinstatement (first page of Form 807 or Form 744 complete) a remittance covering all premiums in arrears, with interest from their several due dates at the rate of 5 per cent per annum.

B. After the expiration of the three calendar months mentioned in clause A, provided the applicant is in good health and submits an application for reinstatement (Form 807) completely executed, with a remittance covering all premiums in arrears with interest from their several due dates at the rate of 5 per cent per annum.

REINSTATEMENT OF UNITED STATES GOVERNMENT TERM OR CONVERTED INSURANCE FOR THOSE SUFFERING FROM DISABILITY OF A SERVICE ORIGIN.

Where the applicant is unable to comply with requirements as outlined above as to his physical condition, either term or converted insurance may be reinstated, provided that the applicant's disability is a result of an injury or disease or of an aggravation thereof suffered or contracted in the active military or naval service during the World War: *Provided further*, That the applicant during his lifetime submits proof satisfactory to the Director showing the serv-

ice origin of the disability or aggravation thereof, and that he is not totally and permanently disabled.

If the insurance is reinstated under this provision, it is necessary to pay all monthly premiums which would have become payable if the insurance had not lapsed, together with interest at the rate of 5 per cent per annum, compounded annually, on each premium from the date said premium is due. Form 742 for term and Form 807 for converted insurance, completely executed, used in these cases.

UNITED STATES VETERANS BUREAU
INSURANCE DIVISION
Form 789—Rev. Dec., 1921

APPLICATION FOR CONVERSION TO U. S. GOVERNMENT LIFE INSURANCE

IN ACCORDANCE WITH THE PROVISIONS OF THE WAR RISK ACT AND BUREAU REGULATIONS

SERIAL NUMBER

USE INK AND MAKE SEPARATE APPLICATION FOR EACH PLAN OF INSURANCE APPLIED FOR.

1 MY NAME IN FULL: (Please print or type.) First. Middle. Last name.

2 HOME ADDRESS: Number. Street or rural route. County, city, town, or post office. State.

MAILING ADDRESS:

3 I WAS BORN AT City, town, or post office. State. Day of month. Month. Year. Age nearest birthday.

4 Weight. Height. Color of hair. Color of eyes.

5 Race and nationality.

6 Rank and organization at time of discharge. Rank, grade, or rating. Organization, regiment, station, ship, etc. Date of enlistment. Date of discharge.

7 Amount of War Risk Term Insurance. $

8 Last month for which term premium was paid.

9 Monthly term premium paid. $

10 Certificate number.

11 I APPLY FOR $..... U. S. GOVERNMENT LIFE INSURANCE ON THE FOLLOWING PLAN: (Make cross mark X under plan selected.)

Ordinary Life.	20-Pay. Life.	30-Pay. Life.
20-yr. Endowment.	30-yr. Endowment.	Endowment at age 62.

12 I WILL PAY PREMIUMS AS INDICATED BELOW: (Make cross mark X under method selected.)

Monthly.	Quarterly.	Semiannually.	Annually.
$.....	$.....	$.....	$.....

If the applicant herein be entitled to this insurance under the War Risk Insurance Act, amendments thereto and regulations made thereunder, this insurance shall be considered as granted and shall become effective as follows: On the first of the month succeeding the date of this application provided the premium on an equal amount of Yearly Renewable Term Insurance, payable on the first of the current month, has been paid. If, however, the premium on an equal amount of Yearly Renewable Term Insurance, payable on the first of the current month, has not been paid, then the converted insurance shall take effect on the first of the current month; but in no event shall the converted insurance take effect until the first premium thereon has been paid.

BENEFICIARY OR BENEFICIARIES OF INSURANCE HEREIN APPLIED FOR IN CASE OF MY DEATH.

13 Relationship to me.	Name of beneficiary. (If married woman her own Christian name and husband's surname must be stated.)	Amt. of Ins. for each beneficiary.	Post-office address. (a) Number and street. (b) City, town, or post office.

14 IN ADDITION TO THE CONVERTED INSURANCE ABOVE APPLIED FOR I WISH TO RETAIN $..... YEARLY RENEWABLE TERM INSURANCE.

15 I SELECT THE OPTION INDICATED BY CROSS MARK X BELOW (see reverse side for instructions):

No. 1 (.....) one sum. | No. 2 (.....) payable in ..... limited installments. | No. 3 (.....) continuous installments.

16 Have you ever made application for Government compensation or pension?

17 If so, state when and give your claim number.

18 Are you now disabled on account of injury or disease?

19 The applicant must remit with this application a sum not less than the amount of the first premium on the converted insurance applied for.
I inclose herewith remittance payable to the TREASURER OF THE UNITED STATES by { Draft / Money order / Check } in the amount of $..... to cover the first ..... premium on the converted insurance.
(Write above whether monthly, quarterly, semiannual, or annual.)

SIGNED AT ..... ON THE ..... DAY OF ....., 192

WITNESSED BY .....

(Applicant sign here. Do not print signature.)

ADDRESS .....

c2—6904

[Page 2 of Form 739.]

OPTIONAL SETTLEMENTS OF UNITED STATES GOVERNMENT LIFE INSURANCE (CONVERTED INSURANCE) AT DEATH

These features do NOT apply to the term (wartime) Insurance

The Insured may select one of the optional settlements set forth below, but notice of the selection shall not be valid unless and until it is recorded in the United States Veterans Bureau. The Insured may revoke his selection of the optional settlement, but the revocation shall not be valid unless and until it is recorded in the United States Veterans Bureau. If the Insured does not select one of said optional settlements, then he shall be deemed to have made no election and the insurance shall be payable in two hundred and forty monthly installments, unless an election under option 2 or 3 is made by the beneficiary.

If the Insured has not made an optional selection at the maturity of this policy by death a designated beneficiary or beneficiaries may select settlement under options 2 or 3 as set forth below, but the selection shall not be valid unless and until it is recorded in the United States Veterans Bureau. If the Insured has made an optional selection at the maturity of this policy by death a designated beneficiary may elect to receive such insurance in installments spread over a greater period of time than that selected by the Insured.

The values shown in the following options are based on an insurance of $1,000 without indebtedness. If there is indebtedness, or the Insured has received any payments on account of total permanent disability, the values will be decreased accordingly. If the policy provides for a larger amount of insurance than $1,000, the values will be increased proportionately.

OPTIONAL SETTLEMENTS IN LIEU OF MONTHLY INSTALLMENTS OF $5.75 PAYABLE ON THE DEATH OF THE INSURED UNDER THE TERMS OF THE POLICY

Option 1. INSURANCE PAYABLE IN ONE SUM. Settlement under this option will be made only when selected by the Insured during his lifetime or by his last will and testament. When such selection has been made the face amount will be payable in one sum at the maturity of the policy by death.

Option 2. INSURANCE PAYABLE IN LIMITED INSTALLMENTS. The installments noted below will be payable for an agreed number of months (not less than 36) to the designated beneficiary, but if such beneficiary dies before the agreed number of monthly installments have been paid, the remaining unpaid monthly installments will be payable in accordance with the beneficiary provisions of the policy.

Number of monthly installments	36	48	60	72	84	96	108	120	132
Amount of each monthly installment	$29.19	$22.27	$18.12	$15.35	$13.38	$11.90	$10.75	$9.83	$9.09
Number of monthly installments	144	156	168	180	192	204	216	228	240
Amount of each monthly installment	$8.46	$7.94	$7.49	$7.10	$6.76	$6.47	$6.20	$5.97	$5.75

Option 3. INSURANCE PAYABLE IN CONTINUOUS INSTALLMENTS. The installments noted below will be payable throughout the lifetime of the designated beneficiary, but if the designated beneficiary dies before 240 such installments have been paid, the remaining unpaid monthly installments will be payable in accordance with the beneficiary provisions of the policy.

Age of beneficiary at time of death of insured.	Amount of installment.	Age of beneficiary at time of death of insured.	Amount of installment.	Age of beneficiary at time of death of insured.	Amount of installment.	Age of beneficiary at time of death of insured.	Amount of installment.
10	$3.67	30	$4.11	50	$5.07	70	$5.75
11	3.69	31	4.15	51	5.13	71	5.75
12	3.70	32	4.18	52	5.19	72	5.75
13	3.72	33	4.22	53	5.24	73	5.75
14	3.73	34	4.26	54	5.29	74	5.75
15	3.75	35	4.30	55	5.35	75	5.75
16	3.77	36	4.34	56	5.39		
17	3.78	37	4.38	57	5.44		
18	3.80	38	4.43	58	5.48		
19	3.82	39	4.48	59	5.53		
20	3.84	40	4.52	60	5.56		
21	3.87	41	4.57	61	5.60		
22	3.89	42	4.63	62	5.63		
23	3.91	43	4.68	63	5.65		
24	3.94	44	4.73	64	5.68		
25	3.96	45	4.79	65	5.70		
26	3.99	46	4.84	66	5.71		
27	4.02	47	4.90	67	5.73		
28	4.05	48	4.96	68	5.74		
29	4.08	49	5.01	69	5.74		

UNITED STATES VETERANS BUREAU
INSURANCE DIVISION
Form 742—Revised Oct., 1921

APPLICATION FOR REINSTATEMENT OF YEARLY RENEWABLE TERM INSURANCE

Applicant must fill out and sign the first page of application for reinstatement in every case. If insurance has lapsed for more than three months, the Medical Examination on the other side is also required.

1. MY NAME IN FULL. (First.) (Middle.) (Last.)
(Please print or type.)

2. Term insurance certificate number.
T-

3. HOME ADDRESS. (Number.) (Street or rural route.) (City, town, or post office.) (State.)

MAILING ADDRESS.

4. I hereby apply for the reinstatement of $..... term insurance granted to me under the provisions of the War Risk Insurance Act, which has now lapsed because I failed to pay the premium for the month of ....., 19....., or within the grace period of 31 days. As a condition to the reinstatement of this insurance, I do hereby certify that the answers to the following questions are true to the best of my knowledge and belief.

5. Are you now in as good health as you were at the due date of the premium in default?

6. Are you at present suffering from any disability which is the result of an injury or disease, or of an aggravation thereof, suffered or contracted in the active military or naval service during the World War? (If so, give full details as to the nature of such disability, disease, or injury, where and when contracted, and what treatment, if any, is being received at this time.)

6-a. Are you now permanently and totally disabled?

7. Have you ever made application for Government compensation or pension?

8. If so, state when and where filed and for what disability.

9. Give your claim number, if any.

10. Have you contracted any disease or suffered any injury since lapse of this insurance? If so, state full particulars, date, name, and address of physician, if one attended you.

11. Have you consulted a physician in regard to your health since lapse of this insurance? If so, state full particulars, date, name, and address of physician.

12. It is agreed that the effective date of the term insurance, if reinstated, shall be the first day of the month in which the requirements have been complied with, unless the applicant requests the Bureau in writing that the effective date shall be the first day of the following month.
I desire this reinstatement to be effective (check below):
☐ The first day of the month in which the requirements have been complied with, or
☐ The first day of the following month.

13. PREMIUMS TENDERED WITH APPLICATION.
(a) For first month of lapse ..... $.....
(b) For month of .....
Reinstatement of Term Ins..... $.....
(c) Advance premium on Term Insurance ..... $.....
(d) For first payment on $..... Government (converted) insurance ..... $.....
Remitted by {check / draft / M. O.} Total..... $.....
Use (b), (c), (d), as they may apply to your case.

14. Signed at ..... on this the ..... day of ....., 19.....

(Signature of applicant.)

Witness:

Section 25 of the War Risk Insurance Act provides that "Whoever • • • makes any statement of a material fact knowing it to be false, shall be guilty of perjury and shall be punished by a fine of not more than $5,000, or by imprisonment for not more than two years, or both."

67—10304

[Page 2 of Form 742.]

MEDICAL EXAMINATION

This examination is necessary only where insurance has lapsed for a period of more than three months.

1. APPLICANT'S OWN STATEMENT

1. Date of birth.	2. Place of birth.	3. Race.	4. Single, married, or widowed

5. Family record.	Age if living.	Health good or bad. (If not good, give full details.)	Age at death.	Cause of death.	Year of death
Father					
Mother					
Sister					
Brother					

6. What operations have you had? Give dates.	7. Have you ever used wines or liquors to excess?	8. Have you ever used opium, morphine, cocaine, or other habit-forming drugs?	9. What is your occupation?

10. Have you ever been treated for any disease of brain or nerves....., throat or lungs....., heart or blood vessels ..., stomach, liver, intestines ..., kidney or bladder ..., genito urinary organs....., skin....., bones....., glands....., ear or eye.....? (Answer "Yes" or "No" by each. If "Yes," describe fully and give date.)

11. Are you now in good health?	Signed by applicant in the presence of medical examiner on this.....day of....., 19....
	(Signature of applicant.)

2. MEDICAL EXAMINER'S REPORT

12. Height in shoes	13. Weight, coat and vest off.	14. Girth of chest, normal .....in.	15. Girth of abdomen.
.....ft. ... in.	Est. ... lbs. or weighing ... lbs	Forced expiration ... in; forced inspiration ... in.	.....in.

16. STATE PULSE RATE:	17. Blood pressure (see Note).	18. Any irregularity or atheroma?
(a) Before exercise..... (c) One minute after exercise ...	Systolic ... Diastolic ...	
(b) Immediately after exercise ... (d) Two minutes after exercise	Instrument used ...	

19. After an examination do you find any abnormality of the lungs....., heart ..., nervous system....., skin....., ear....., eye....., abdomen..... or digestive system .....? (Answer "Yes" or "No" by each. If "Yes," describe fully.)

20. URINALYSIS:
Specific gravity..... Albumin..... Test used..... Have you knowledge that the urine examined was passed by the applicant at the
Reaction..... Sugar..... Test used ... time of examination?.....

21. Has applicant ever had syphilis, gout, or rheumatism?	22. Any defects in the sight or hearing?	23. Any deformity or departure from normal in any respect?

24. Has the applicant lost an eye, hand or arm, foot or leg?	25. Is the ability to work impaired in any way? If so, state particulars.	26. Do you recommend acceptance of the risk?
		1st Cl. risk Fair risk Poor risk

27. Are you related to applicant by blood or marriage?	28. Was this examination made at your home or office, or at applicant's home? State place and address.	29. Are answers to questions of medical examiner's report in your own handwriting?

30. FEMALES: Any history of uterine or ovarian diseases?	Married: if pregnant, month advanced.	Date of last confinement. Was it normal?	Number of miscarriages, if any, and dates.

31. Are you satisfied that everything has been fully stated regarding the physical condition, habits, personal and family history of the applicant?.....

32. REMARKS:

Examination made and signed this.....day of....., 19.....

.....
(Name of State in which you are licensed to practice medicine.)

.....
(Signature.)

NOTES.—Blood pressure is required (a) when applicant is more than thirty years of age, (b) in all cases where there is a family history of apoplexy, heart disease, or nephritis; or where there is a personal history of gout, rheumatism, syphilis, heart disease, or any evidence of kidney disease.

Section 25 of the War Risk Insurance Act provides that "Whoever • • • makes any statement of a material fact knowing it to be false, shall be guilty of perjury and shall be punished by a fine of not more than $5,000, or by imprisonment for not more than two years, or both."

82—10201
GOVERNMENT PRINTING OFFICE

UNITED STATES VETERANS BUREAU
INSURANCE DIVISION
Form 807—Revised Nov., 1921

APPLICATION FOR REINSTATEMENT OF GOVERNMENT LIFE INSURANCE

Applicant must fill out and sign the first page of application for reinstatement in every case. If insurance has lapsed for more than three months, the Medical examination on reverse side of this form is also required.

1. My name in full. (Please print or type.) (First.) (Middle.) (Last name.)

2. Policy number. K-

3. My home address (Street and No.) (City, town, or post office.) (State.)

Mailing address

4. I hereby apply for the reinstatement of $..... Government Life Insurance granted to me under the provisions of the War Risk Insurance Act, now lapsed for the nonpayment of premium for the month of ....., 192 , or within the grace period of thirty-one days. As a condition to the reinstatement of this insurance, I do hereby certify that the answers to the following questions are true to the best of my knowledge and belief.

5. Are you now in as good health as you were at the due date of the premium in default?

6. Are you at present suffering from any disability which is the result of an injury or disease, or of an aggravation thereof, suffered or contracted in the active military or naval service during the World War? (If so, give full details as to the nature of such disability, disease, or injury, where and when contracted, and what treatment, if any, is being received at this time.)

7. Have you contracted any disease or suffered any injury since lapse of this insurance? If so, state full particulars, date, and name and address of physician, if one attended you.

8. Have you consulted a physician in regard to your health since lapse of this insurance? If so, state full particulars, date, name and address of physician.

9. Are you now permanently and totally disabled?

10. Have you ever made application for Government compensation or pension?

11. If so, state when and for what disability.

12. Give your claim number, if any.

13. Premiums tendered with application:

(a) Total of all premiums in arrears ..... $.....

(b) Interest on premium to date .. $.....

(c) Payment of any indebtedness on my policy ..... $.....

Remitted by {Check, Draft, M. O.,} Total ..... $.....

A loan or other indebtedness may be reinstated in accordance with terms of the policy.

14. Signed at ..... on this the ..... day of ....., 192...

WITNESS: .....

.....
(Signature of applicant.)

NOTE.—Section 25 of the War Risk Insurance Act provides that "Whoever * * * makes any statement of a material fact, knowing it to be false, shall be guilty of perjury and shall be punished by a fine of not more than $5,000, or by imprisonment for not more than two years, or both."

62—8680

[Page 2 of Form 807.]

MEDICAL EXAMINATION

This examination is necessary only where insurance has lapsed for a period of more than three months.

1. APPLICANT'S OWN STATEMENT

1. Date of birth.	2. Place of birth.	3. Race.	4. Single, married, or widowed

5. Family record.	Age if living.	Health good or bad. (If not good, give full details.)	Age at death.	Cause of death.	Year of death
Father					
Mother					
Sister					
Brother					

6. What operations have you had? Give dates.	7. Have you ever used wines or liquors to excess?	8. Have you ever used opium, morphine, cocaine, or other habit-forming drugs?	9. What is your occupation?

10. Have you ever been treated for any disease of brain or nerves ....., throat or lungs....., heart or blood vessels. ....., stomach, liver, intestines ....., kidney or bladder....., genito urinary organs....., skin....., bones....., glands....., ear or eye.....? (Answer "Yes" or "No" by each. If "Yes," describe fully and give date.)

11. Are you now in good health?	Signed by applicant in the presence of medical examiner on this..... .....day of..... ....., 19..
	(Signature of applicant.)

2. MEDICAL EXAMINER'S REPORT

12. Height in shoes.	13. Weight, coat and vest off.	14. Girth of chest, normal .....in.	15. Girth of abdomen.
.....ft. ..... in.	Est. ..... lbs. or weighing .....lbs.	Forced expiration. ... in; forced inspiration .... in.	..... .in.

16. STATE PULSE RATE:	17. Blood pressure (see Note).	18. Any irregularity or atheroma?
(a) Before exercise..... (c) One minute after exercise.....	Systolic..... Diastolic.....	
(b) Immediately after exercise..... (d) Two minutes after exercise	Instrument used	

19. After an examination do you find any abnormality of the lungs....., heart ....., nervous system....., skin....., ear....., eye....., abdomen..... or digestive system.....? (Answer "Yes" or "No" by each. If "Yes," describe fully.)

20. URINALYSIS: Specific gravity..... Albumin..... Test used..... Reaction ..... Sugar..... Test used.....	Have you knowledge that the urine examined was passed by the applicant at the time of examination? .....

21. Has applicant ever had syphilis, gout, or rheumatism?	22. Any defects in the sight or hearing?	23. Any deformity or departure from normal in any respect?

24. Has the applicant lost an eye, hand or arm, foot or leg?	25. Is the ability to work impaired in any way? If so, state particulars.	26. Do you recommend acceptance of the risk? 1st Cl. risk... Fair risk... Poor risk...

27. Are you related to applicant by blood or marriage?	28. Was this examination made at your home or office, or at applicant's home? State place and address.	29. Are answers to questions of medical examiner's report in your own handwriting?

30. FEMALES: Any history of uterine or ovarian diseases?	Married: If pregnant, month advanced.	Date of last confinement. Was it normal?	Number of miscarriages, if any, and dates.

31. Are you satisfied that everything has been fully stated regarding the physical condition, habits, personal and family history of the applicant?.....

32. REMARKS:

.....

Examination made and signed this..... ....day of..... 19.....

(Name of State in which you are licensed to practice medicine.) (Signature.)

NOTES.—Blood pressure is required (a) when applicant is more than thirty years of age, (b) in all cases where there is a family history of apoplexy, heart disease, or nephritis; or where there is a personal history of gout, rheumatism, syphilis, heart disease, or any evidence of kidney disease.

Section 25 of the War Risk Insurance Act provides that "Whoever * * * makes any statement of a material fact knowing it to be false, shall be guilty of perjury and shall be punished by a fine of not more than $5,000, or by imprisonment for not more than two years, or both."

o2—10201

GOVERNMENT PRINTING OFFICE

LIBRARY OF CONGRESS
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DESCRIPTION OF FORMS.

Form No.

501.—Emergency information.
506.—Investigation brief.
512.—Letter asking for further information as to relatives.
514.—Affidavit in support of insurance claim.
524.—Affidavit of person claiming to have stood in relation of parent.
526.—Application of person disabled in and discharged from the service.
527.—Application of widow, child, or/and dependent parent.
530.—Letter requesting additional information as to the identity of claimant.
532.—Notice of unclaimed mail—requesting correct address from postmaster.
533.—Abstract of marriage certificate.
534.—Abstract of certificate of baptism.
541.—Affidavit in proof of insurance claim.
545.—Abstract of certificate of discharge.
547.—Affidavit of identification.
556.—Surrender of pensions of gratuity.
557.—Letter asking evidence in proof of widow's claim to automatic insurance.
562.—Application for insurance by guardian of minor beneficiary.
562–A.—Letters requesting information as to designation of beneficiary.
562–B.—Letter requesting written evidence by insured to identify insurance application.
567.—Request to American Red Cross to field investigator for completion of proof in insurance case.
568.—Letter requesting further information, as Form 526 is incomplete.
577.—Claim of parent for automatic insurance.
581.—Letter asking vocational claimant regarding war-risk insurance claims.
582.—Letter regarding pay to Federal board.
583.—Letter to ex-service man requesting information as to claim.
667.—Request for affidavits to connect disability with service.
686.—Letter requesting claimant to submit additional affidavit to connect disability with service.
687.—Letter asking claimant to report for a physical examination.
689.—Letter explaining to claimant what affidavits are necessary to connect disability with service.
2545.—Report of physical examination from United States Public Health Service (Vocational.)
2507.—Request for physical examination.
2519.—Letter requesting additional medical evidence.
2520.—Letter requesting additional medical evidence.
2522.—Affidavit regarding claimant's disability.
2523.—Physician's statement.
2524.—Follow-up for 2507.
2527.—Request for additional medical evidence.

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